

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02614

2644

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Wicomico
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Cambridge	LENGTH OF STAY (in this place) 1 mo. 15 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 EASTERN SHORE STATE HOSPITAL	STREET ADDRESS (If rural give location) ---		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) Carrie	(Middle) Ella (Chappell)	(Last) Barr	March 31 1955
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W	8. DATE OF BIRTH: May 14, 1859
9. AGE last birthday 95 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: ---	11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: Martin Chappell	
14. MOTHER'S MAIDEN NAME: Eliza Sayer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) ---	
16. SOCIAL SECURITY NO. ---		17. INFORMANT & ADDRESS: RECORDS: Eastern Shore State Hospital	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Chronic Myocarditis		Several years	
ANTECEDENT CAUSE (B) Generalized Arteriosclerosis		Several years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Senility		Several years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile Psychosis		About 2 years	
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-16- , 19 55 to 3-31 , 19 55 that I last saw the deceased alive on 3-31 , 19 55 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
SIGNATURE Robert H. Reddick		ADDRESS M.D. Cambridge, Md.	DATE SIGNED 3/31/55
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 4-3-55	NAME OF CEMETERY OR CREMATORY First Methodist	LOCATION (City, town, or county) (State) Delmar, Delaware
DATE REC'D BY LOCAL REGISTRAR 3-31-55	REGISTRAR'S SIGNATURE John Mace Jr. M.D.	24. FUNERAL DIRECTOR W.D. Sparr Co - Delmar, Del	ADDRESS

RECEIVED

APR 4 1955

BUREAU V. S.

2627

02615

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 114

1. PLACE OF DEATH:

COUNTY Dorchester MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cambridge LENGTH OF STAY (in this place) 12 hours
 TOWN Cambridge
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge-Maryland Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Dorchester
 CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Hurlock X
 STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED:

(First) (Middle) (Last)
Hilton Lee Berdaux

4. DATE OF DEATH (Month) (Day) (Year)
March 31, 19 55

5. SEX:

male

6. COLOR OR RACE:
negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
single

8. DATE OF BIRTH:

January 20, 1955

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
 yrs. Months Days Hours Min.
2 11

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country):
Hurlock, Maryland

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME:

Alvin B. Berdaux

14. MOTHER'S MAIDEN NAME:

Nellie Blount

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
No

16. SOCIAL SECURITY No.:
None

17. INFORMANT & ADDRESS:

Alvin B. Berdaux, Hurlock, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

527.2
 Immediate cause (a) Acute respiratory infection
 DUE TO

Antecedent cause(s)
 Diseases or conditions, if any, giving rise to the above cause DUE TO
 stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH
3 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?
 Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. While at work ☐ Not while at work ☐

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John Mace Jr.

CHIEF MEDICAL EXAMINER ☐
 DEPUTY MEDICAL EXAMINER ☒
 ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED

M. D.

3-31-55

23. BURIAL, CREMATION, REMOVAL (Specify):
Burial

DATE THEREOF
April 2, 1955

NAME OF CEMETERY OR CREMATORY
Washington Cemetery

LOCATION (City, town, or county) (State)
Near Hurlock, Maryland

DATE REC'D BY LOCAL REG.
April 2, 1955

REGISTRAR'S SIGNATURE
John Mace Jr. M.D.

24. FUNERAL DIRECTOR

J. J. Frampton, Federalsburg, Md.

ADDRESS

4015231406

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 5 1955
BUREAU V. S.

RECEIVED
APR 5 1955
BUREAU V. S.

MARYLAND

2628

02616

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>	
TOWN <u>Cambridge</u>		TOWN <u>Vienna</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md.</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Morril Spear Blades</u>		4. DATE OF DEATH <u>3/3</u> (Month) (Day) (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>4/27/1875</u>
9. AGE last birthday <u>79</u> yrs.		10. UNDER 1 year Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
12. BIRTHPLACE (State or foreign country) <u>Maryland</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>John D. Bradley</u>		15. MOTHER'S MAIDEN NAME <u>Sarah (don't know last)</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY No. <u>Walter Spear, Vienna Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>acute Pulmonary Edema</u>		<u>1 hour</u>
Antecedent cause(s)		
(b) <u>Congestive Heart Failure</u>		<u>5 days</u>
(c) <u>arterio-sclerotic Hypertensive Cardiovascular Renal Disease</u>		<u>4 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-2, 1955, to 3-3, 1955, that I last saw the deceased

alive on 3-3, 1955, and that death occurred at 10:50 P.M., from the causes and on the date stated above.

SIGNATURE Eldridge H. Wolford ADDRESS Cambridge Md. DATE SIGNED 3-6-55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/6/55</u>	<u>Vienna</u>	<u>Vienna</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-8-55</u>	<u>John Mace Jr. M.D.</u>	<u>Walter S. Hollingsworth</u>	<u>East New Market Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 9 1925

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 116

2645

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Dorchester</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Palbot</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge, rural</u> LENGTH OF STAY (in this place) <u>1 mo., 17 days</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bozman</u> <u>20X-2</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>			STREET ADDRESS (If rural give location) <u>✓</u>		
3. NAME OF DECEASED: (Type or Print)			4. DATE (Month) (Day) (Year)		
(First) <u>NORMAN</u> (Middle) <u>LAMONT</u> (Last) <u>BRUNDAGE</u>			OF DEATH: <u>Mar.</u> <u>21</u> <u>19 55</u>		
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>4/12/94</u>		
9. AGE last birthday <u>60</u> yrs.			IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>lawyer</u>			10B. KIND OF BUSINESS OR INDUSTRY:		
11. BIRTHPLACE (State or foreign country): <u>New Jersey</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME: <u>John N. Brundage</u>			14. MOTHER'S MAIDEN NAME: <u>Martha Reichert Riskey</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>yes</u> (If Yes, give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital records</u>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>422.2</u>		
IMMEDIATE CAUSE	(A) <u>Chronic myocarditis</u>	<u>unk.</u>
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE	(B) <u>Pneumonia</u>	<u>unk.</u>
STATING UNDERLYING CAUSE LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Alzheimer's Disease</u>		<u>unk.</u>

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 4, 1955 to March 21, 1955 that I last saw the deceased alive on Mar. 21, 1955, and that death occurred at 9:40 AM, from the causes and on the date stated above.

SIGNATURE <u>Thomas J. Dudge</u>		ADDRESS <u>M. D. E.S.S.H. Cambridge, Md.</u>		DATE SIGNED <u>3/21/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>3/24/55</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Orange New Jersey</u>
DATE REC'D BY LOCAL REGISTRAR <u>3-22-55</u>	REGISTRAR'S SIGNATURE <u>John M. M. D.</u>	24. FUNERAL DIRECTOR <u>John. L. L. Harrison, St. Michaels</u>		ADDRESS

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 24 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 46

2646

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>17 mo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	<u>23X-9</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>MATTIE</u>	(Middle) <u>DEVEREAUX</u>	(Last) <u>CLAYVILLE</u>	OF DEATH: <u>March 6 1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>5-20-1871</u>
9. AGE last birthday <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Mins.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Joseph J. Devereaux</u>		14. MOTHER'S MAIDEN NAME: <u>Hennetta Beavens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital records</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>		<u>5 yrs +</u>
ANTECEDENT CAUSE (B) <u>Generalized Arteriosclerosis</u>		<u>10 yrs +</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) <u>Cancer left heart</u>		<u>1 yr +</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION: <u>None</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-15, 1953, to 3-6, 1955, that I last saw the deceased alive on 3-6, 1955, and that death occurred at 9:52 PM, from the causes and on the date stated above.

SIGNATURE <u>George E. Curries</u>	ADDRESS <u>Cambridge, Md.</u>	DATE SIGNED <u>3-6-55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>March 9/55</u>	NAME OF CEMETERY OR CREMATORY <u>Whatcoat</u>
LOCATION (City, town or county) <u>Snow Hill</u>	(State) <u>Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-9-55</u>	REGISTRAR'S SIGNATURE <u>John W. MacFarland, M.D.</u>	FUNERAL DIRECTOR <u>Wm. C. Dinnick, Snow Hill, Md</u>

MARGIN RESERVED FOR HINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 11 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2647

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Centerville</u>		ca 5 yrs.		OR TOWN <u>Centerville</u> 17X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
16 <u>Western Shore State Hospital</u>				-----			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>Mary</u>		(Middle) <u>Louise</u>		(Last) <u>Connolly</u>		OF DEATH: <u>March 7 1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>1-13-1876</u>	
				9. AGE last birthday <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joshua Chance</u>				14. MOTHER'S MAIDEN NAME: <u>Anna W. Wyatt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital Records</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				INTERVAL BETWEEN ONSET AND DEATH			
420.0				5 yrs. plus			
(A) <u>Arteriosclerotic Heart Disease</u>							
DUE TO							
ANTECEDENT CAUSE (S)							
(B) <u>Generalized Arteriosclerosis</u>				10 yrs. plus			
DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>none</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-7</u> , 19 <u>53</u> , to <u>3-7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-7</u> , 19 <u>55</u> , and that death occurred at <u>2:50</u> ^a M, from the causes and on the date stated above.							
SIGNATURE <u>George E. Currier</u>				ADDRESS <u>Centerville, Md.</u>		DATE SIGNED <u>3-7-55</u>	
M. D. <u>Centerville, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar. 9, 1955</u>		<u>Centerville</u>		<u>Centerville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>March 7, 1955</u>		<u>John Mace Jr. m. d.</u>		<u>Barton Bros.</u>		<u>Centerville, Maryland.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR

BUREAU V. E.

02621

MARYLAND 2648

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 112

1. PLACE OF DEATH COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Vienna</u> TOWN <u>Vienna</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u> TOWN <u>Vienna</u> STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Deborah</u> (First) <u>Lavinia</u> (Middle) <u>Corkran</u> (Last)		4. DATE OF DEATH <u>3</u> / <u>12</u> / <u>1955</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH <u>2/12/1877</u>
9. AGE last birthday <u>78</u> yrs.		10. AGE last birthday <u>78</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William B. Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Mary Corkran</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>011-12-1234</u>	
17. INFORMANT AND ADDRESS <u>Miss Jane A. Corkran, Vienna, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>490.1</u>		<u>Arterio Coronary occlusion</u>	<u>sudden</u>
Antecedent cause(s) (b) <u>Generalized Arteriosclerosis</u>			<u>10 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, or office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3/11/55</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1/1, 1955, to 3/12, 1955, that I last saw the deceased alive on 3/11, 1955, and that death occurred at 12:30 a.m., from the causes and on the date stated above.

SIGNATURE <u>Laurine Maryann M.D.</u>		ADDRESS <u>Cambridge, Md.</u>		DATE SIGNED <u>3/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>3/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Vienna</u>	
LOCATION (City, town, or county) <u>Vienna, Md.</u>		(State) <u>Md.</u>			
DATE REC'D BY LOCAL REG. <u>3/15/55</u>		REGISTRAR'S SIGNATURE <u>Elizabeth H. Beale</u>		24. FUNERAL DIRECTOR <u>East New Market, Md.</u>	

MARGIN RESERVED FOR BINDING

3 2 10/1903

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1802622
2649
CERTIFICATE OF DEATH

Reg. Dist. No. 112

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Dorchester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Vienna	LENGTH OF STAY (In this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Vienna	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS (If rural give location) 1	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Hurden	(Middle) Selven	(Last) Demby	OF DEATH: March 26 1955
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: S Oct. 15, 1914
9. AGE last birthday 40 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed		10B. KIND OF BUSINESS OR INDUSTRY: None	
11. BIRTHPLACE (State or foreign country): Vienna, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Luther Edward Demby		14. MOTHER'S MAIDEN NAME: Mary Alice Parker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: Luther E. Demby, Vienna, Maryland			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis Far Advanced			
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 23 Mar, 1955 to 26 Mar, 1955 , that I last saw the deceased alive on 26 Mar, 1955 , and that death occurred at 5:30 PM , from the causes and on the date stated above.			
SIGNATURE J. EDWIN FASSETT		ADDRESS 227 Pine St-Camb., Md.	
DATE SIGNED 28 Mar 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 29, 1955	
NAME OF CEMETERY OR CREMATORY Vienna Cemetery		LOCATION (City, town, or county) (State) Vienna, Maryland	
DATE REC'D BY LOCAL REGISTRAR March 29, 1955		REGISTRAR'S SIGNATURE Clayton H. Brall	
24. FUNERAL DIRECTOR J.J. Frampton and Son, Federalsburg, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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1200

2629

CERTIFICATE OF DEATH

Reg. Dist. No. 116...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Dorchester
CITY (If outside corporate limits, write RURAL and give nearest town) OR 13 TOWN Cambridge	LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge 13	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Phillips Street Extd.		STREET ADDRESS (If rural give location) Phillips Street Extd.	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) DAISY	(Middle) WARFIELD	(Last) GANBY	(Month) Mar. (Day) 7 (Year) 19 55
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: July 4, 1887
9. AGE last birthday: 67 yrs.		10. BIRTHPLACE (State or foreign country): Dorchester County, Md	
11. BIRTHPLACE (State or foreign country): Dorchester County, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Henry Warfield		14. MOTHER'S MAIDEN NAME: Henrietta Ward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No. 222-05-6518	
17. INFORMANT & ADDRESS: Dora Harris, Cambridge, Maryland			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
443X IMMEDIATE CAUSE (A) Congestive Heart Failure			6 Mos
ANTECEDENT CAUSE (B) Hypertension CVD			?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) arterio-sclerotic			?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Stervation			4 Mos
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Mar 7, 1955 to Mar 7, 1955 that I last saw the deceased alive on Mar 7, 1955 , and that death occurred at 109 A.M. from the causes and on the date stated above.			
SIGNATURE W. Thompson		ADDRESS Cambridge, Md DATE SIGNED Mar. 8, 55	
M.D. Cambridge, Md			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/11/1955	
NAME OF CEMETERY OR CREMATORY Waugh Cemetery		LOCATION (City, town, or county) (State) Cambridge, Maryland	
DATE REC'D BY LOCAL REGISTRAR 3-10-55		REGISTRAR'S SIGNATURE John M. G. m. d.	
24. FUNERAL DIRECTOR Herbert M. St. Clair, Jr.		ADDRESS Cambridge, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2630

CERTIFICATE OF DEATH

Reg. Dist. No. 116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>1 Cambridge</u>	
TOWN <u>Cambridge</u>		TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge-Md. Hospital</u>		STREET ADDRESS (If rural, give location) <u>102 Franklin St.</u>	
3. NAME OF DECEASED (First) <u>Claude</u> (Middle) <u>S.</u> (Last) <u>Gootee</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>27</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>3-14-1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sea food dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea food</u>	9. AGE last birthday <u>55</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Gootee</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Willey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Claude L Gootee Jr. Cambridge, Maryland</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Heart failure</u>			<u>2 wks</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Coronary Thrombosis</u>			<u>6 wks</u>
(c) <u>Intero - Prolapsus valv</u>			<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from....., 1953, to Mar 27, 1955, that I last saw the deceased alive on Mar 27, 1955, and that death occurred at 7:45 P m., from the causes and on the date stated above.

SIGNATURE <u>James H. Thompson M.D.</u>	ADDRESS <u>Cambridge Md</u>	DATE SIGNED <u>Mar 27, '55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-29-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>
LOCATION (City, town, or county) <u>Cambridge, Maryland</u>		(State)
DATE REC'D BY LOCAL REG. <u>3-29-55</u>	REGISTRAR'S SIGNATURE <u>John Mace M.D.</u>	24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>
		ADDRESS <u>Cambridge, Maryland</u>

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2631

CERTIFICATE OF DEATH

02625

Reg. Dist. No. 116 ...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>5 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67 448 High Street</u>				STREET ADDRESS (If rural give location) <u>448 High Street</u>		<u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>SUDIE</u> <u>HARMANSON</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 11 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>August 15, 1892</u>	
				9. AGE last birthday: <u>62 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>16</u> Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Accomac County, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>John Sturgis</u>				14. MOTHER'S MAIDEN NAME: <u>Anne Haley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Susie Matthews, Cambridge, Maryland</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>1 day</u>	
DUE TO							
ANTECEDENT CAUSE (B) <u>Hypertensive Arteriosclerotic Heart Disease</u>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Sept 54</u> , 19 <u>54</u> to <u>11 Mar 55</u> , that I last saw the deceased alive on <u>11 Mar 19 55</u> and that death occurred at <u>11:15</u> , from the causes and on the date stated above.							
SIGNATURE <u>John Macas, M.D.</u>				ADDRESS <u>227 Rue</u>		DATE SIGNED <u>15 March 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal-Burial</u>		DATE THEREOF <u>2/16/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Pungoteague Cemetery</u>		LOCATION (City, town, or county) (State) <u>Accomac County, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-16-55</u>		REGISTRAR'S SIGNATURE <u>John Macas, M.D.</u>		24. FUNERAL DIRECTOR <u>Herbert M. St. Clair, Jr.</u>		ADDRESS <u>Cambridge, Md.</u>	

10/10/10

10/10/10

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2650 CERTIFICATE OF DEATH

Reg. Dist. No.

02626

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge		LENGTH OF STAY (in this place) 12 yrs. 11 mos.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parsonsburg 22X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS EASTERN SHORE STATE HOSPITAL		12 days		STREET ADDRESS (If rural give location) ----- ✓			
3. NAME OF DECEASED: (First) Thomas (Middle) William (Last) Hitchens				4. DATE (Month) (Day) (Year) OF DEATH: March 23 1955			
5. SEX Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W		8. DATE OF BIRTH: July, 1867	
9. AGE last birthday 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Levin Hitchens				14. MOTHER'S MAIDEN NAME: Julia Arvey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown		16. SOCIAL SECURITY NO. ---		17. INFORMANT & ADDRESS: RECORDS: Eastern Shore State Hospital			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
592X IMMEDIATE CAUSE (A) Coronary Occlusion						72 hours	
ANTECEDENT CAUSE (S) DUE TO (B) Chronic Nephritis						unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) Psychosis with Cerebral Arteriosclerosis						12 yrs. /	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-12-1954 , to 3-23, 1955 , that I last saw the deceased alive on 3-23, 1955 , and that death occurred at 9:10 PM , from the causes and on the date stated above.							
SIGNATURE Harry G. Crawford		ADDRESS M. D. ESS Hosp. Cambridge Md.		DATE SIGNED March 24, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried		DATE THEREOF March 26-55		NAME OF CEMETERY OR CREMATORY McNeill Mem. Park Salisbury Md.		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR 3/25/55		REGISTRAR'S SIGNATURE John M. ...		24. FUNERAL DIRECTOR William R. G. Salisbury Md.		ADDRESS	

BUREAU V. S.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02627
2651 CERTIFICATE OF DEATH Reg. Dist. No. 16

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge,	LENGTH OF STAY (in this place) 1 mth. 10 das.	CITY: If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin, Maryland 23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Shore State Hosp.		STREET ADDRESS (If rural give location) --	
3. NAME OF DECEASED:		4. DATE OF DEATH.	
(First) Eva	(Middle) M.	(Last) Holland	(Month) March (Day) 22 (Year) 1955
5. SEX. F	6. COLOR OR RACE. W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH. June 29, 1889
9. AGE last birthday. 65 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: James Nock		14. MOTHER'S MAIDEN NAME: Ella (maiden name unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT & ADDRESS Eastern Shore State Hosp. Records			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) Bronchopneumonia		7 days.
ANTECEDENT CAUSE (B) Generalized arteriosclerosis		2 yrs. plus
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Chronic Myocarditis		2 yrs. plus
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with cerebral arteriosclerosis		2 yrs. plus
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	19C. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 12, 1955 to Mar. 22, 1955 that I last saw the deceased alive on Mar. 22, 1955 , and that death occurred at 12:40 P.M. from the causes and on the date stated above.			
SIGNATURE Robert H. Reddick		ADDRESS Cambridge, Md.	
DATE SIGNED 3/22/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 3-24-55	NAME OF CEMETERY OR CREMATORY Buckingham	LOCATION (City, town, or county) (State) Berlin Wor. Co. Md.
DATE REC'D BY LOCAL REGISTRAR 3-24-55	REGISTRAR'S SIGNATURE John M. ...	24. FUNERAL DIRECTOR Anna A. Burbage	ADDRESS Berlin, Md.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 28

RECEIVED

2632

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>13</u> TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>7</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> <u>12</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>				STREET ADDRESS (If rural give location) <u>Franklin Street</u> <u>1</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <u>HATTIE</u>		(Middle) <u>HURLEY</u>		(Last) <u>HURST</u>		MARCH 25 19 55	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>7-4-1878</u>	
9. AGE last birthday <u>76</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Charles Hurley</u>				14. MOTHER'S MAIDEN NAME: <u>Henrietta Lane</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr. Dorsey Potter: Cambridge, Maryland</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hemiplegia Right</u>						<u>9 days</u>	
ANTECEDENT CAUSE (B) <u>arteriosclerotic C V R Disease</u>						<u>6 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Parkinson's Syndrome</u>						<u>3 mo.</u>	
19A. DATE OF OPERATION: <u> </u>				19B. MAJOR FINDINGS OF OPERATION: <u> </u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY -street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-16</u> , 195 <u>8</u> , to <u>3-25</u> , 195 <u>8</u> , that I last saw the deceased alive on <u>3-25</u> , 195 <u>8</u> , and that death occurred at <u>8:20</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edridge H. Hoff</u>				ADDRESS <u>Cambridge, Md</u>		DATE SIGNED <u>28 March 1958</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-28-1955</u>		<u>Cambridge Cemetery</u>		<u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-28-55</u>		REGISTRAR'S SIGNATURE <u>John Mace, M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02629

2652

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>2 mos. 20 das.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bozman</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural give location) <u>--</u>			
3. NAME OF DECEASED: (First) <u>Bessie</u> (Middle) <u>Catherine</u> (Last) <u>Jump</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March</u> <u>28</u> <u>19</u> <u>55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH <u>May 15, 1876</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Gustavus Steilkie</u>				14. MOTHER'S MAIDEN NAME: <u>Nettie (Maiden name unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>--</u>		15. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital Records</u>			
16. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>						2 yrs. plus	
ANTECEDENT CAUSE (B) <u>Chronic Myocarditis</u>						2 yrs. plus	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>Psychosis with Cerebral Arteriosclerosis</u>						unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>January 8, 1955</u> to <u>March 28, 1955</u> , that I last saw the deceased alive on <u>Mar. 28</u> , 1955, and that death occurred at <u>3:35 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Reddick</u>		M.D. <u>Cambridge, Md.</u>		DATE SIGNED <u>3/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bozman Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bozman Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-30-55</u>		REGISTRAR'S SIGNATURE <u>John Mace, M.D.</u>		24. FUNERAL DIRECTOR <u>H. H. Harrison</u>		ADDRESS <u>H. H. Harrison</u>	

FORM 1.5

100-100000

2653

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL) OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN Williamsburg		Life		TOWN Williamsburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Henrietta Lake				March 16 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	Colored	Married	August 2, 1893	61 yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		
Housework				Home	Dorchester County, Maryland		
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
No data available				Ella M. Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
No				220-01-9022		Elwood Lake, Williamsburg, Maryland	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) Cerebral vascular accident							2-3 days
ANTECEDENT CAUSE (S) (B) Hypertensive Cardiovascular disease							1-2 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-22, 1955 , to 3-13, 1955 , that I last saw the deceased alive on 3-13, 1955 , and that death occurred at 12:50 M , from the causes and on the date stated above.							
SIGNATURE Robert C. Kingsbury				ADDRESS Federalsburg Md.		DATE SIGNED 3-16-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		March 20, 1955		Skinner's Run Cemetery		Near Williamsburg, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
March 20-1965		Charles Hastings		J.J. Frampton and Son, Federalsburg, Md.			

MARGIN RESERVED FOR BINDING

U. S. ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

1910

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

02631

Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Dorchester			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cambridge				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cambridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 208 Maryland Avenue				STREET ADDRESS (If rural, give location) 208 Maryland Avenue			
3. NAME OF DECEASED (Type or Print)		(First) REBECCA		(Middle) WHEREETTE		(Last) LANTZ	
4. DATE OF DEATH		(Month) March		(Day) 15		(Year) 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 5-15-1875	9. AGE last birthday 79 yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Thomas Wherette			
14. MOTHER'S MAIDEN NAME Not Known				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY No. none				17. INFORMANT AND ADDRESS William M. Lantz, Cambridge, Maryland			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
450.1 Immediate cause (a) Coronary occlusion Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE <i>John M. M. D.</i>				ADDRESS Medical Examiner Dorchester Co., 3-17-55			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 3-17-1955		NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		LOCATION (City, town, or county) (State) Cambridge, Maryland	
DATE REC'D BY LOCAL REG. 3-17-55		REGISTRAR'S SIGNATURE <i>John M. M. D.</i>		24. FUNERAL DIRECTOR LeCompte Funeral Service		ADDRESS Cambridge, Maryland	

2654

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02632

Reg. Dist. No. 110

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamstown B.C.D.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamstown R.F.D. X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
(First) (Middle) (Last) <u>Cyrus C Lord</u>		<u>March 13, 1955</u>	
6. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 8, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>	9. AGE last birthday <u>73 yrs.</u>
11. FATHER'S NAME <u>Thomas J. Lord</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME <u>Mary Bell</u>		14. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>218-204831</u>	
17. INFORMANT AND ADDRESS <u>Ray Lord - Williamstown, Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Strangulated inguinal hernia

INTERVAL BETWEEN ONSET AND DEATH

2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar. 11, 1955, to Mar. 11, 1955, that I last saw the deceasedalive on Mar. 11, 1955, and that death occurred at 7 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Robert C. Kingsbury MDFederalburg Md.3-14-55

23. BURIAL, CREMATION, RESTORATION (Specify)	DATE TIME OF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>March 15, 1955</u>	<u>Zion Cemetery</u>	<u>Federalburg Md. B.C.D.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>March 15, 1955</u>	<u>Charles Hastings</u>	<u>J. Harvey Williamson</u>	<u>Federalburg Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2655

CERTIFICATE OF DEATH

Reg. Dist. No. 116

02633

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Cambridge</u>		3 yrs. 9 mos.		OR TOWN <u>St. Michaels</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural give location) <u>---</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>Emma B. Marshall</u>				OF DEATH: <u>March 23 19 55</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>August 29, 1863</u>	
9. AGE last birthday: <u>91</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>			
13. FATHER'S NAME: <u>Henry Burrows</u>				14. MOTHER'S MAIDEN NAME: <u>Frances W. Byrd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>---</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital Records</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						4 days	
ANTECEDENT CAUSE (B) <u>Generalized Arteriosclerosis</u>						5 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chronic myocarditis</u>						5 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis with Cerebral Arteriosclerosis</u>						5 yrs.	
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Dec. 1</u> , 19 <u>51</u> , to <u>March 23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 23</u> , 19 <u>55</u> , and that death occurred at <u>10:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Simon Vincent</u>				ADDRESS <u>Cambridge, Md.</u>			
DATE SIGNED <u>March 23, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/26/55</u>		<u>Oliver Cemetery</u>		<u>St. Michaels. Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3/24/55</u>		<u>John M. M. D.</u>		<u>J. H. Hackett</u>		<u>Harrison, St. Michaels</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 5

MAR 28 1977

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2634

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>1 mo</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>		STREET ADDRESS (If rural give location) <u>124 Locust Street</u>	
3. NAME OF DECEASED: (First) <u>RONALD</u> (Middle) <u>H.</u> (Last) <u>MURPHY</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>MARCH 29 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>6-27-1914</u>
9. AGE last birthday <u>40 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Self Employed General Trucking</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Homer H. Murphy</u>	
14. MOTHER'S MAIDEN NAME: <u>Maude Meekins</u>		15. INFORMANT & ADDRESS: <u>Mrs. Edith A. Varner: West Pt., Va.</u>	
16. SOCIAL SECURITY NO. <u>214-07-8207</u>		17. MEDICAL CERTIFICATION	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I IMMEDIATE CAUSE (A) <u>Metastatic embryonal carcinoma lungs</u>		18 Mo.	
ANTECEDENT CAUSE (B) <u>Embryonal carcinoma testicle</u>		2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>12/22/53</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Embryonal carcinoma testicle</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/22/53</u> ..., to <u>3/29/55</u> 19 ..., that I last saw the deceased alive on <u>3/29/55</u> 19 ..., and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>John Mace Jr.</u>		ADDRESS <u>Cambridge, Md.</u>	
DATE SIGNED <u>3/31/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-31-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 2, 1955</u>		REGISTRAR'S SIGNATURE <u>John Mace Jr. M.D.</u>	

MARGIN RESERVED FOR BINDING

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2635

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cambridge</u>		<u>35 yrs.</u>		TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Cambridge Md. Hospital</u>				<u>140 A Washington Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>MARY L. PINDER</u>				<u>March 10, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.			
<u>Female</u>	<u>Negro</u>	<u>Single</u>	<u>May 16, 1889</u>	<u>65 yrs.</u>	<u>9</u> Months	<u>24</u> Days	<u></u> Hours <u></u> Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Unemployed</u>		<u>None</u>		<u>Dorchester County, Md</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Norris Cephas</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
<u>***-***-***</u>		<u>None</u>		<u>James Johnson, Cambridge, Maryland</u>			

18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>175X</u> Immediate cause (a) <u>Myocardial Failure</u> Antecedent causes (s) (b) <u>Decubitus ulcer (long)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Carcinoma ovary metastases.</u>						<u>3 days</u> <u>6 wks</u> <u>6 yrs</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bilateral Paralysis Cervicobrachial</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/6</u> , 19 <u>55</u> , to <u>3/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/10</u> , 19 <u>55</u> , and that death occurred at <u>Cambridge, Md</u> , from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
<u>[Signature]</u>		<u>MD</u>		<u>Cambridge, Md</u>		<u>3/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/15/1955</u>		<u>Bethel Cemetery</u>		<u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-15-55</u>		<u>John Mace Jr. M.D.</u>		<u>Herbert M. St. Clair, Jr., Cambridge, Md.</u>			

MARGIN RESERVED FOR BINNING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V

1955

2656

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Rhodesdale</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rhodesdale</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Daisy</u> <u>Pinkett</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 18</u> <u>19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>July 11, 1884</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	11. BIRTHPLACE (State or foreign country): <u>Dorchester Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Frank Mowbray</u>				14. MOTHER'S MAIDEN NAME: <u>Eliza Matthews</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Viola Pinkett, Rhodesdale, Maryland</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>							
ANTECEDENT CAUSE (B) <u>Hypertensive Arteriosclerotic</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Heart Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1 Mar</u> , 19 <u>55</u> to <u>18 Mar</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>18 Mar</u> , 19 <u>55</u> , and that death occurred at <u>8:30 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Edwin Fasset</u>				ADDRESS <u>J. EDWIN FASSETT M.D. -227 Pine St-Camb., Md.</u>		DATE SIGNED <u>-21 Mar 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Thompsontown Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near East New Market, Md.</u>	
DATE REG'D BY LOCAL REGISTRAR <u>March 22/1955</u>		REGISTRAR'S SIGNATURE <u>Charles Hoeling</u>		24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02637

2657

CERTIFICATE OF DEATH

Reg. Dist. No. *116*

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>X</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Fruitland, Md.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>16 Eastern Shore State Hosp. Cambridge.</i>				STREET ADDRESS (If rural give location)		<i>22 X - 2v</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Georgia Benson Pusey</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>17 March 31 1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>		8. DATE OF BIRTH: <i>August 28 1886</i>	
9. AGE last birthday: <i>68</i> yrs.		10. AGE last birthday: <i>68</i> yrs.		11. AGE last birthday: <i>68</i> yrs.		12. AGE last birthday: <i>68</i> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>-</i>			
11. BIRTHPLACE (State or foreign country): <i>Md.</i>				12. CITIZEN OF WHAT COUNTRY: <i>U.S.</i>			
13. FATHER'S NAME: <i>George Benson.</i>				14. MOTHER'S MAIDEN NAME: <i>Mary (Maiden name unknown).</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <i>-</i>				16. SOCIAL SECURITY NO.: <i>-</i>			
17. INFORMANT & ADDRESS: <i>Eastern Shore State Hospital Records.</i>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <i>Coronary occlusion</i>							
ANTECEDENT CAUSE (B) <i>Chronic Myocarditis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Generalized Arteriosclerosis</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Psychosis with Coronary Arteriosclerosis</i>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 24, 1954</i> to <i>March 31 1955</i> that I last saw the deceased alive on <i>March 31, 1955</i> , and that death occurred at <i>5:10 P. M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Robert H. Reddick</i>				ADDRESS <i>Cambridge, Md.</i> DATE SIGNED <i>3/31/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>April 3 1955</i>		<i>St. Pauls Cemetery</i>		<i>Near Marion Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<i>4-8-55</i>		<i>John Mace, Jr. M.D.</i>		<i>Holloway & Co. Salisbury</i>		<i>Salisbury</i>	

BUREAU V. S.

2636

02638

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 111

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Cambridge</u>		<u>life</u>		TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>27 High Street</u>				STREET ADDRESS (If rural, give location) <u>27 High Street</u>			
3. NAME OF DECEASED: (First) <u>J.</u>		(Middle) <u>RICHARD</u>		(Last) <u>SMITH</u>		4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>8</u> (Year) <u>19 55</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>8-6-1889</u>	
9. AGE last birthday: <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Gordy Smith</u>				14. MOTHER'S MAIDEN NAME: <u>Mary E. Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>WW I</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Richard L. Smith: Cambridge, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>47+X</u> Immediate cause (a) <u>Strangulation</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>5 min.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>home</u>		21c. (City or town) <u>Cambridge</u> (County) <u>Dorchester</u> (State) <u>Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3-8-55 1:10PM.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Hanged self with sashcord.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John Macen</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-10-55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-11-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Old Trinity Cemetery</u>		LOCATION (City, town, or county) (State) <u>Church Creek, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>3-10-55</u>		REGISTRAR'S SIGNATURE <u>John Macen M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RIEVE FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

2637

02639

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland COUNTY Dorchester			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cambridge		LENGTH OF STAY (in this place) 10 years		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cambridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge-Maryland Hospital				STREET ADDRESS (If rural, give location) 123 Locust St.			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
Bessie		May		Tegtmeier			
4. DATE OF DEATH		(Month)		(Day)		(Year)	
Mar. 30, 1955		19					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
Female	White	Widowed	July 19, 1877	77	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Pocomoke City, Md.		U.S.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Frank Townsend				Francis Fannie Townsend			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
no		none		Mrs. Chas. B. Roberson, 123 Locust St., Cambridge			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a)..... Coronary occlusion DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....						2 hrs..	
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY?							
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County)	
						(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
John Mace		Apr. 1, 1955		Mt. Moriah Cemetery		Philadelphia, Pa.	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
Burial		3-30-55		John Mace Jr. M.D.		Kenneth R. Thomas, Cambridge, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10

2638

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 02640

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Deleware</u>	COUNTY <u>Sussex</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>	LENGTH OF STAY (In this place) <u>1 week</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Milford</u>	<u>46 X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>		STREET ADDRESS (If rural, give location) <u>421 S. Washington St.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>LEONARD</u>	(Middle) <u>J.</u>	(Last) <u>TODD</u>	(Month) <u>MARCH</u> (Day) <u>10</u> (Year) <u>19 55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9-6-1913</u>
9. AGE last birthday: <u>41 yrs.</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Frozen Food Indust.</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Edgar Todd</u>	
14. MOTHER'S MAIDEN NAME: <u>Elsie McGlaughlin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unknown</u>	
16. SOCIAL SECURITY No.: <u>not known</u>		17. INFORMANT & ADDRESS: <u>Mrs. Tesse Todd: Milford, Deleware</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) Immediate cause DUE TO <u>Parylitic ileus</u>		<u>2 days</u>
(b) Antecedent cause(s) DUE TO <u>Bile peritonitis</u>		<u>2 days</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>3/7/55</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
19b. MAJOR FINDING OF OPERATION: <u>Cholecystitis, cholelithiasis</u>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>John Mac</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-12-55</u>
M. D. <u>John Mac</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>3-13-1955</u>	NAME OF CEMETERY OR CREMATORY: <u>Dorchester Memorial Park</u>
LOCATION (City, town, or county) (State): <u>Cambridge, Maryland</u>	24. FUNERAL DIRECTOR: <u>LeCompte Funeral Service</u>	
DATE REC'D BY LOCAL REG. <u>3-13-55</u>		ADDRESS: <u>Cambridge, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02641

2658

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Dorchester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge	LENGTH OF STAY (in this place) 11 mos. 20 ds.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 110 West End Avenue	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Shore State Hospital	STREET ADDRESS (If rural give location) Cambridge		
3. NAME OF DECEASED: (First) J. (Middle) Holliday (Last) Warfield		4. DATE OF DEATH: (Month) March (Day) 29 (Year) 19 55	
5. SEX: M	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower	8. DATE OF BIRTH: 9-29-75
9 AGE last birthday 79 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Storekeeper		10B. KIND OF BUSINESS OR INDUSTRY: -	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: John R. Warfield	
14. MOTHER'S MAIDEN NAME: Sarah Smith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) unknown	
16. SOCIAL SECURITY NO. --		17. INFORMANT & ADDRESS: Eastern Shore State Hospital Records	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) Carcinoma of liver			over 1 year
ANTECEDENT CAUSE (B) Generalized Arteriosclerosis			over 1 year
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Chronic Myocarditis			over 1 year
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis W. Psy. Reac.			over 11 mos.
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April 12 1954, to 3-29, 1955, that I last saw the deceased alive on 3-29, 1955, and that death occurred at 5:07 PM, from the causes and on the date stated above.			
SIGNATURE Harry J. Crawford M.D.		ADDRESS M. D. E.S.S. Hospital, Cambridge, Maryland	
DATE SIGNED 3-30-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-31-55	
NAME OF CEMETERY OR CREMATORY Speddens Cemetery		LOCATION (City, town, or county) (State) James, Maryland	
DATE REC'D BY LOCAL REGISTRAR 3-31-55		REGISTRAR'S SIGNATURE John Macdonald M.D.	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge		ADDRESS	

2639

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dor</u>	
CITY (If outside corporate limits, write RURAL, and give nearest town) <u>13 TOWN Cambridge</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL, and give nearest town) <u>TOWN Cambridge</u>		<u>13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>137 Washington St</u>				STREET ADDRESS (If rural give location) <u>137 Washington St</u>			
3. NAME OF DECEASED: (First) <u>Samuel</u>		(Middle) <u>Morgan</u>		(Last) <u>Waters</u>		4. DATE OF DEATH: (Month) <u>March</u> (Day) <u>20</u> (Year) <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Mar-7-1873</u>		9. AGE last birthday: <u>82</u> yrs. <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>- -</u>		11. BIRTHPLACE (State or foreign country): <u>Upper Hill-Som., Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME: <u>Levin T. Waters</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Waters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>- -</u>		16. SOCIAL SECURITY No.: <u>217-10-8127</u>		17. INFORMANT & ADDRESS: <u>Mrs. Josephine Waters-Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>440.0</u> Immediate cause (a) <u>Cardiac Decompensation</u> DUE TO Antecedent cause(s) (b) <u>Arteriosclerotic heart disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?				Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6 Mar, 1955</u> , to <u>20 Mar</u> , 1955, that I last saw the deceased alive on <u>20 Mar</u> , 1955, and that death occurred at <u>from the causes and on the date stated above.</u>							
SIGNATURE <u>J. Edwin Fasset</u>		(Degree or title)		ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-24-55</u>		<u>Bethel Cemetery</u>		<u>Cambridge-Dor-Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-22-55</u>		<u>John Mace Jr. M.D.</u>		<u>H.M. StClair, Jr.</u>		<u>High St-Camb., Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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2640

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13 TOWN Cambridge</u>		LENGTH OF STAY (in this place) <u>44 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> <u>13</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>115 Choptank Avenue</u>				STREET ADDRESS (If rural give location) <u>115 Choptank Avenue</u> <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ZACHARIAH</u> <u>-</u> <u>WHEATLEY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>MARCH</u> <u>1</u> <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>11-20-1873</u>	9. AGE last birthday: <u>81</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Well Driller</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic Water Wells</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Wheatley</u>				14. MOTHER'S MAIDEN NAME: <u>Henrietta Palmer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <u>unknown</u>		16. SOCIAL SECURITY NO.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr. Steele Wheatley: RFD#3 Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) DUE TO		<u>Coronary occlusion</u>		<u>2 days</u>	
ANTECEDENT CAUSE (S)		(B) DUE TO		<u>Cerebral Hemorrhage</u>		<u>1 day</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/28</u> , 19 <u>55</u> , to <u>3/1</u> , 19 <u>55</u> that I last saw the deceased alive on <u>3/1</u> , 19 <u>55</u> , and that death occurred at <u>4³⁰</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>Lawrence Manyan</u>		M.D. <u>Cambridge Md</u>		ADDRESS <u>3/13/55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-4-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-4-55</u>		REGISTRAR'S SIGNATURE <u>John Mac Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

EDWARD K. B.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>		Life		TOWN <u>Cambridge</u>		2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
07 <u>Race Street Extended</u>				<u>105 Pine Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>EVERETT M. WILSON</u>				OF <u>March 18, 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Nov. 11, 1896</u>	
				9. AGE last birthday: <u>58 yrs.</u>		IF UNDER 1 YEAR: <u>4</u> Months <u>7</u> Days	
						IF UNDER 24 HRS. <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Food-Packing</u>		11. BIRTHPLACE (State or foreign country): <u>Cambridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Robert Wilson</u>				14. MOTHER'S MAIDEN NAME: <u>Hattie Clash</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Robert Wilson, Cambridge, Maryland</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
812x Immediate cause		(a) <u>laceration of brain</u>				<u>immed.</u>	
		DUE TO					
Antecedent cause(s)		(b) <u>Compound fracture of skull</u>				<u>immed.</u>	
Diseases or conditions, if any, giving rise to the above cause		DUE TO					
stating underlying cause last		(c) <u>Fracture of cervical spine</u>				<u>immed.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Race Street</u>		21c. (City or town) <u>Cambridge</u> (County) <u>Dorchester</u> (State) <u>Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3 18 55 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>struck by car</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED			
<u>Reuben R. Maryanor</u>		DEPUTY MEDICAL EXAMINER		<u>3/22/55</u>			
		ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3/22/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE RECD BY LOCAL REG. <u>3/22/55</u>		REGISTRAR'S SIGNATURE <u>John Mace, M.D.</u>		24. FUNERAL DIRECTOR <u>Herbert M. St. Clair, Jr.</u>		ADDRESS <u>Cambridge, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2642 CERTIFICATE OF DEATH

02645

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Dorchester
CITY (If outside corporate limits, write RURAL, and give nearest town) 13 TOWN Cambridge	LENGTH OF STAY (in this place) 50 yrs.	CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN Cambridge 13	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 9 Schoolhouse Lane		STREET ADDRESS (If rural give location) 229 High Street	
3. NAME OF DECEASED: (First) (Middle) (Last) Alexander Woolford		4. DATE (Month) (Day) (Year) OF DEATH: Mar. 25, 1955	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH: Oct. 15, 1889
9. AGE last birthday 65 yrs.		IF UNDER 1 YEAR: Months 5 Days 10 Hours 10 Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Pool Parlor	
11. BIRTHPLACE (State or foreign country): Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Alexander Woolford		14. MOTHER'S MAIDEN NAME: Elizabeth Creighton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. 214-07-8955	
17. INFORMANT & ADDRESS: Mrs Beulah Molock, R.F.D. 2, Camb., Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Cardiac Decompensation			
ANTECEDENT CAUSE (S) DUE TO			
(B) Hypertensive Arteriosclerotic Heart Disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertrophy & Urinary obstruction			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 29 Jan, 1955 to 25 Mar, 1955 , that I last saw the deceased alive on 25 Mar, 1955 , and that death occurred at 5 A M , from the causes and on the date stated above.			
SIGNATURE J. EDWIN FASSETT, M.D.		ADDRESS 227 Pine St-Camb., Md. DATE SIGNED 28 Mar 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/28/1955	
NAME OF CEMETERY OR CREMATORY Cordtown Cemetery		LOCATION (City, town, or county) (State) Cordtown, Dor. Co., Md.	
DATE REC'D BY LOCAL REGISTRAR 3-28-55		REGISTRAR'S SIGNATURE John Mac, Jr. M.D.	
24. FUNERAL DIRECTOR		ADDRESS Herbert M. St. Clair, Jr., Cambridge, Md.	

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APR 4 1955

BUREAU V. S.

2643

02646

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 116

1. PLACE OF DEATH:

COUNTY Dorchester

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN CambridgeLENGTH OF STAY
(in this place)
1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Dorchester

CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN Cambridge

STREET ADDRESS (If rural, give location)

Colonial Avenue

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

Virginia Bell Wroten

4. DATE
OF
DEATH

(Month) (Day) (Year)

March 7, 19 55

5. SEX:

female

6. COLOR OR
RACE:

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

married

8. DATE OF BIRTH:

11-23-1935

9. AGE last birthday:

19

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):

Housewife

10b. KIND OF BUSINESS OR
INDUSTRY:

Own home

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT
COUNTRY?

U. S. A.

13. FATHER'S NAME:

J. Henry Bell

14. MOTHER'S MAIDEN NAME:

Melvina Bromwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

no

16. SOCIAL SECURITY No.:

none

17. INFORMANT & ADDRESS:

Henry Bell, Cambridge, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

353.3

Immediate cause

(a) Myocardial Failure

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b)

Convulsions- Epilepsy

DUE TO

(c)

Old birth injury

INTERVAL BETWEEN
ONSET AND DEATH

16 hrs.

entire life

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY21e. INJURY OCCURRED
While at Not while
work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and
find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John Mace Jr.

CHIEF MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED

3-10-55

23. BURIAL, CREMATION,
REMOVAL (Specify):

Burial

DATE THEREOF

3-10-55

NAME OF CEMETERY OR CREMATORY

East New Market

LOCATION (City, town, or county)

East New Market, Md.

DATE REC'D BY LOCAL
REG.

3-10-55

REGISTRAR'S SIGNATURE

John Mace Jr. M.D.

24. FUNERAL DIRECTOR

LeCompte Funeral Service
Cambridge, Maryland

ADDRESS

MARGIN RESERVED FOR BINDING

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VS. A15A - 5 - 53

BUREAU V. S.

MAY 16 1915

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